

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER The Commons on St Anthony, A S N F & Short T R C		STREET ADDRESS, CITY, STATE, ZIP CODE 3 St Anthony Street Auburn, NY 13021	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the services arranged or provided by the facility meet professional standards of quality for one of six residents reviewed. Specifically, Resident #2 had increased confusion, urinary frequency and a strong urine odor, a physician order was obtained for a urinalysis, culture and sensitivity and Resident #2's urine sample was not collected to rule out a urinary tract infection. Findings include: The 04/01/2024 facility policy, Change in a Resident's Condition or Status documented a significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without interventions by staff or by implementing standard disease-related clinical interventions. The undated facility policy, Laboratory Specimens Collection of Routine Urine Specimen documented explain procedure to resident, bring equipment to the bedside and provide privacy. Require resident to urinate, place urine in specimen cup and immediately label with resident's name and room number, complete lab request form and place it in a biohazard bag and send it to the laboratory. Chart procedure in nursing record, indicate color, odor and quantity and include pertinent observations. Resident #2 had diagnoses of syncope (fainting due to low heart rate), right femoral neck fracture status post right hemiarthroplasty of hip (hip fracture repair) and unspecified non-Alzheimer's dementia. The 09/26/2024 Minimum Data Set assessment documented Resident #2 had severely impaired cognition, was dependent on staff for toileting hygiene and toileting transfers, was frequently incontinent of bladder and bowels, and required nutrition/hydration interventions to manage skin conditions. The 09/23/2024 lack of capacity form signed by their health care proxy and Nurse Practitioner #18 documented Resident #2 had dementia and their medical decision-making capacity was poor. The 10/10/2024 at 1:27 PM nursing progress note by Registered Nurse Unit Manager #14 documented Resident #2 had been lethargic for the past few days, had a decreased appetite, had increased confusion, urinary frequency with odor, required more physical assistance from staff and developed a dry, intermittent cough. The resident agreed they did not feel well. Nurse Practitioner #18 was notified, and an order was obtained for a urinalysis with culture and sensitivity and cough syrup three times a day for seven days. The 10/10/2024 untimed physician order by Nurse Practitioner #18 documented obtain urinalysis with culture and sensitivity to rule out urinary tract infection for increased confusion, urinary frequency and malodor (strong urine odor) 10/10 one time only to obtain urinalysis with culture and sensitivity for three days. There was no documented evidence the medical order for a urinalysis was transcribed to the treatment administration records, a laboratory requisition form was created, or a urine sample was collected from Resident #2. The 10/12/2024 at 10:48 AM nursing progress note by Registered Nurse #19 documented the resident's family was insistent the resident be sent to the emergency department for evaluation due to increased confusion, a urinalysis was ordered, and the family did not want to wait until Monday. Registered Nurse #19 documented the resident seemed stable and did not want to go to the emergency department. The family representative was coming to the facility to evaluate and speak with the resident. The 10/12/2024 at 11:29 AM nursing progress note by Licensed Practical Nurse #16 documented Resident #2's family member had phoned the unit five times and had requested the resident's urinalysis results. Licensed (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse #16 stated they did not have the results, the resident had refused to go to the emergency department and a visitor from their assisted living facility arrived to evaluate them. Resident #2 changed their mind, Emergency Medical Services was phoned, and the resident went to the Emergency Department at 11:25 AM. Fluid intakes for Resident #2 documented: -On 10/10/2024 at 9:32 PM- resident refused- On 10/11/2024 at 10:07 AM and 2:37 PM- resident refused- On 10/12/2024 at 11:48 AM- resident refused. There was no documented evidence that a provider was notified regarding the resident's decreased fluid intake or change in condition. There was no documented evidence the 10/10/2024 urine sample was collected from Resident #2 prior to leaving for the hospital on [DATE]. During an interview on 06/23/2026 at 10:20 AM, Licensed Practical Nurse #15 stated if a resident had symptoms of a urinary tract infection, the registered nurse supervisor would obtain a physician order to collect a urine sample and fill out a lab form. The order would show on the resident's treatment record. They would know how to collect a urine sample when the order appeared on the treatment record. Licensed Practical Nurse #15 stated they were unsure where a urine specimen went once it was collected and if the order was finished, the registered nurse supervisor would remove the order from the computer. During an interview on 06/23/2026 at 10:44 AM, Registered Nurse Unit Manager #14 stated if a resident showed signs and symptoms of a urinary tract infection, which may be increased confusion, having to urinate all the time or a strong odor, an infection screening questionnaire was required to be completed. If the screening indicated a possible infection, the physician would be notified, and either the physician would enter an order for a urine sample, or they would give a verbal order to the registered nurse to enter. The licensed practical nurse working on the unit would need to confirm the order before collecting the urine sample and place a laboratory slip into the lab binder on the unit. The facility utilized the local hospital for labs and specimens. If a urine sample was collected for Resident #2, it would have been documented on the 24-hour report sheet, and the lab slip would have been missing out of the lab book. Urine samples were collected and brought to the Supervisor's office and placed into the refrigerator for pick up. Results for a urinalysis should be available either the same day or the next day. There was no documented evidence Resident #2 was placed on the 24-hour report sheet for 10/10/2024-10/12/2024. During an interview on 06/23/2026 at 3:30 PM, Medical Technologist #17 stated they worked in the laboratory of the local hospital. There was evidence of a urine sample collected for Resident #2 on 10/12/2024 at 1:20 PM and resulted at 1:39 PM. Medical Technologist #17 stated the urine was collected while the resident was an inpatient in the Emergency Department and not the facility. During an interview on 06/24/2026 at 12:30 PM, the Director of Nursing stated if a resident exhibited signs of a urinary tract infection, they would expect nursing to obtain the resident's vital signs and an order from a provider for a urine sample. Orders are typically collected within three days, but they would expect it to be collected immediately if a resident was showing symptoms. The facility did not keep the laboratory requisitions. The Director of Nursing stated if a resident was not drinking well and exhibited symptoms of a urinary tract infection, they would expect nursing to push fluids and notify a provider to see if they would want nursing to obtain a urine sample via a straight catheter. If family was insistent on the resident going to the hospital and the resident had poor medical decision making, they would expect nursing to send the resident to the hospital. It was not appropriate for nursing to wait two to three days after the resident was exhibiting symptoms of a urinary tract infection. The resident's Health Care Proxy should be notified and included in the decision making. Urine sample results were usually ready in a day. 10 NYCRR 483.21 Comprehensive Resident Centered Care Plan		